Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $6,930.00 for dates of service 04/17/01 through 06/01/01.

   b. The request was received on 03/11/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 04/16/02
   b. HCFA(s)-1500
   c. TWCC 62 forms
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60
   b. HCFA(s)-1500
   c. TWCC 62 forms
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 04/23/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 05/01/02. The response from the insurance carrier was received in the Division on 05/16/02. Based on 133.307 (i) the insurance carrier's response is untimely so the Commission shall issue a decision based on the request and the carrier's initial response.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 04/16/02:
(Provider)'s position is that the fees paid for these services by the carrier were not 'fair and reasonable.'….Examples of what other insurance companies reimbursed…for CPT 97799-CPAP during the service dates….The claims are credible evidence of our billed rate is 'fair and reasonable.'…(Provider) is also enclosing a study it conducted in 2001. The study surveyed what insurance companies were paying for CPT 97799-CPAP…More of the insurance companies paid $175 than any other single fee….Recent decisions by TWCC's Medical Dispute Resolution Officers also supports (Provider)'s position that $175 per hour for CPT 97799 is a fair and reasonable fee…(Provider)'s assertion that its fees are fair and reasonable has been upheld in a recent SOAH decision….Judge…noted… 'A rate of $175.00 per hour for pain management program services…is a fair and reasonable charge….We believe this evidence supports our premise that the fees paid by the carrier are not 'fair and reasonable.'"

2. Respondent: TWCC 60:
"Reduced According to fee guidelines."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 04/17/01 through 06/01/01.

2. Per the TWCC 60, the provider billed the carrier $34,650.00 for disputed dates of service 04/17/01 through 06/01/01 for CPT code 97799 CP-AP.

3. The carrier reimbursed the provider $27,720.00 for the disputed dates of service.

4. The correct amount in dispute for dates of service in dispute is $6,930.00.

5. The carrier denied billed services by code:
"F – Reduced According to Fee Guideline";
"M – Reduced to Fair and Reasonable".

V. RATIONALE

Medical Review Division's rationale:

Medical Fee Guideline Medicine Ground Rule (II) (B) states, "…Accreditation by CARF is recommended, but not required, for all interdisciplinary programs….This ground rule applies to the interdisciplinary programs which are…Chronic Pain Management." MFG MGR (II) (G) (9) states, "Chronic Pain Management shall be billed as code 97799-CP for each day….DOP is required." In accordance with the General Ground Rules (III) (A), "Documentation of Procedure (DOP) in the maximum allowable reimbursement (MAR) column indicates that the value of this service shall be determined by written documentation attached to or included in the bill. DOP is used when the services provided are not specifically listed or are unusual or too variable to have an assigned MAR." MFG GR (VI) states, "A MAR is listed for each code excluding

…(DOP)….The insurance carrier will reimburse the lesser of the billed charge, or the MAR. CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at the fair and reasonable rate." Rule 135.305 (e) (1) (F) includes that "if the dispute involves treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with § 133.1…" Rule 133.1 refers to § 413.011 (b) which states, "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

Because there is no current fee guideline for Chronic Pain Management programs, the Medical Review Division has to determine what would be fair and reasonable reimbursement for the services provided. The provider submitted EOB(s) from other carriers showing the payment rate of carrier reimbursement to provider 100% of billed charges. The provider also submitted a list of forty-five insurance companies that reimbursed the provider from $92.00 an hour to $175.00 an hour. Regardless of the carrier's lack of methodology or response, the burden is on the provider to show that the amount of reimbursement requested is fair and reasonable. The burden remains on the provider to show that the amount of reimbursement requested is fair and reasonable. The provider's documentation is EOB(s) or is based on EOB(s). However, analysis of recent decisions of the State Office of Administrative Hearings indicate minimal weight is given to EOB(s) for documenting fair and reasonable reimbursement. The willingness of some carriers to provide reimbursement at or near the billed amount does not necessarily document that the billed amount is fair and reasonable and does not show how effective medical cost control is achieved, a criteria identified in Sec. 413.011(b) of the Texas Labor Code. The EOB(s) prove no evidence of amounts paid on behalf of managed care patients or on behalf of other non-workers' compensation patients with an equivalent standard of living. Therefore, based on the evidence available for review, the provider is not entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 2nd day of August 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.